

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

1846

State File No. \_\_\_\_\_

FILED FEB 11 1942  
94-93

Registration District No. \_\_\_\_\_

Primary Registration District No. 4055

Registrar's No. 3

1. PLACE OF DEATH:

(a) County Caldwell  
(b) City or town Braymer, Mo  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: \_\_\_\_\_  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community 6 weeks years, months or days

3. (a) PRINT FULL NAME Shelby Jean Simkins

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex female 5. Color or race white 6. (a) Single, widowed, married, divorced \_\_\_\_\_  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Dec. 20, 1948 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
X 1 10 hr. min.

9. Birthplace Braymer, Mo (City, town, or county) (State or foreign country)

10. Usual occupation Infant

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Charles Simkins  
13. Birthplace Braymer, Mo (City, town, or county) (State or foreign country)  
14. Maiden name Ethel Whitworth  
15. Birthplace Braymer, Mo (City, town, or county) (State or foreign country)

16. (a) Informant Charlie Simkins  
(b) Address Braymer, Mo

17. (a) Burial (b) Date thereof 1-31-42 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cowdell, Mo

18. (a) Signature of funeral director Prinett Mead

(b) Address Braymer, Mo

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Caldwell  
(c) City or town Braymer (If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 30 year 1942 hour 4 minute 30 P. M.

21. I hereby certify that I attended the deceased from Jan 30 1942, to \_\_\_\_\_ 1942; that I last saw him alive on Jan 20 1942; and that death occurred on the date and hour stated above.

Immediate cause of death Congenital malformation of heart  
Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) 1512

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature Geo. S. Dowell (M. D. or other) \_\_\_\_\_  
Address Braymer, Mo Date signed Jan 31 42

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by

Registered Apprentice No.

working under my personal supervision.

Signed

*This body was not embalmed*

Licensed Embalmer No. *2501*

P. O. Address *Bayona, Tex*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 1844  
Registrar's No. ....

Registration District No. 93

Primary Registration District No. 4055

1. PLACE OF DEATH:

- (a) County Caldwell  
(b) City or town Praymer  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: \_\_\_\_\_  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days)

3. (a) PRINT  
FULL NAME

Shelby J. Simkins

3. (b) If veteran,

name war \_\_\_\_\_

3. (c) Social Security

No. \_\_\_\_\_

4. Sex

7

5. Color or  
race W

6. (a) Single, widow, married,  
divorced S

6. (b) Name of husband or wife

6. (c) Age of husband or wife if  
alive \_\_\_\_\_ years

7. Birth date of deceased

(Month)

(Day)

(Year)

8. AGE:

Years

Months

Days

(If less than one day

min.

9. Birthplace

(City, town, or county)

(State or foreign country)

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace

(City, town, or county)

(State or foreign country)

14. Maiden name

15. Birthplace

(City, town, or county)

(State or foreign country)

16. (a) Informant

(b) Address

17. (a)

(Burial, cremation, or removal)

(b) Date thereof

(Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a)

(Date received local registrar)

(b)

E. A. Thompson

(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 2  
year 1942 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_;  
that I have seen him/her live on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_  
Duration \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN

Underline  
the cause to  
which death  
should be  
charged sta-  
tistically.

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
(Specify type of place)  
While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other)

Address \_\_\_\_\_ Date signed \_\_\_\_\_

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

